

# Commonwealth of Kentucky Personnel Cabinet

## Department for Employee Insurance

### 2006 Dependent Add Form

This form must be used for any qualifying event (QE) that allows you to add dependents to your plan. Complete a Health Insurance Application for election changes such as option changes, new coverage, new waiver or to begin a cross-reference plan with your spouse.

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Applicant's SSN

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Retiree's SSN (if applicable)

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Company Number

Name (First, MI, Last) \_\_\_\_\_  
(PRINT)

To be eligible to add a dependent to your health insurance plan, you must certify that you have experienced the QE as listed here. The QE's listed on this form are the only events that allow you to ADD dependents to your plan. To be considered an eligible dependent, your dependent MUST meet one of the conditions below:

- ☐ Your Legal Spouse; or
- ☐ Your unmarried child, stepchild, foster child that will be under age 24 in the current plan year, and depends on the employee for more than 50% of his/her support and maintenance and lives in the household in a parent-child relationship.  
(Exception: Court Orders and Administrative orders to provide health coverage for the child. OR the child is a full time dependent attending college.)

**NOTE: EFFECTIVE DATE FOR COVERAGE IS 1<sup>ST</sup> DAY OF THE FOLLOWING MONTH FROM MEMBER'S SIGNATURE DATE ON ADD FORM. (Exception: Birth, Birth plus, Adoption/Placement and placement for Adoption are effective the DATE of the event)**

#### Qualifying Events: (Check one)

- ☐ Birth newborn only (60 days)
- ☐ Birth plus other dependents (30 days)
- ☐ Adoption\*/ Placement for Adoption\* (60 days)
- ☐ Adoption\*/ Placement for Adoption\* plus other dependents (30 days)
- ☐ Legal guardianship\*, Administrative Order\* or court order pertaining to health insurance
- ☐ Marriage
- ☐ Sp/Retiree has different Open Enrollment period\*
- ☐ Sp/Dep loses other coverage\*
- ☐ Sp/Dep loses governmental group coverage\*
- ☐ Significant cost increase/ (Dependent Care changes ONLY)
- ☐ Unmarried dependent re-establishes eligibility\* (member must supply information on reason to re-establish eligibility)
- ☐ Other \_\_\_\_\_

Qualifying Event Date (mm/dd/yy): \_\_\_\_\_

Note: SP = Spouse DEP = Dependent

\* Supporting documentation required

**PRINT the following information for each dependent to be added:**

Social Security Number	Name (First, MI, Last)	Gender (Circle One)	Date of Birth	Rel.Code **
		M F		
		M F		
		M F		
		M F		

\*\* Rel. Code: SP = Spouse / CH = Child / CO = Court Ordered Dependent / DD = Disabled Dependent /

**Applicable to employees of State agencies ONLY (Commonwealth Choice). All other employees must contact their Insurance Coordinator for specific information about the employer's Flexible Spending Account Program. Retirees are not eligible to participate in an FSA.**

#### Healthcare Spending Account

I request as change in my "per check" deduction

From \$\_\_\_\_\_ to \$\_\_\_\_\_ employee money

From \$\_\_\_\_\_ to \$\_\_\_\_\_ employer money

#### Dependent Care Account

I request a change in my "per check" deduction

From \$\_\_\_\_\_ to \$\_\_\_\_\_ employee money

My signature below certifies that I understand the statements on this form and that all the information provided by me is true and complete to the best of my knowledge. I understand that any person who knowingly and with intent to defraud any insurance company or other person, files this form containing any materially false information or conceals, with the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I understand that any material misrepresentation or material omission contained herein may be used to void this contract.

Applicant Signature

Date

Insurance Coordinator Signature

Date

Retiree Signature

Date

Signatures are required below if changes to an existing cross-reference plan are being requested

Spouse Signature

Date

Spouse Insurance Coordinator Signature

Date